

From the Roer to the Elbe With the 1st Medical Group: Medical Support of the Deliberate River Crossing

by
Captain Donald E. Hall



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FOREWORD

Casualties are an inevitable consequence of battle, and they are commonly listed at the end of historical accounts as figures for dead and wounded. The assumption, on reading these numbers, is that the dead were at some point, during or after the battle, collected and the wounded treated. Rarely do battle analysts devote more than passing attention to the medical support provided these combatants.

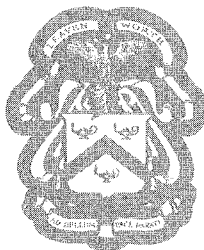
Captain Donald E. Hall, in his special study on the 1st Medical Group in World War II, reminds us that procedures for treating the wounded have evolved considerably since those days when death or amputation seemed the foregone alternatives for a serious wound to an appendage. By World War II, medical support provided by the U.S. Army in combat had modified extensively and employed multiple echelons of health care. Advances in medicine, medical science, and medical treatment also had improved the care of soldiers wounded under the dangerous and unpredictable conditions of the modern battlefield.

Captain Hall describes for us the difficulties confronted in river-crossing operations, where the removal and flow of casualties runs counter to the general flow of traffic to the front. Hall's study is timely and properly emphasizes the necessity for including medical support in meaningful battle analyses.



January 1992

Roger J. Spiller
Director
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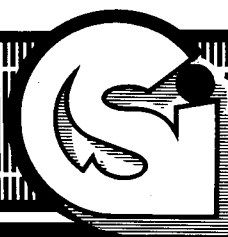


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CIP

The smallest detail, taken from actual incident in war, is more instructive to me, a soldier, than all the Thiers and Jominis in the world.

— ARDANT DU PICQ
Battle Studies

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PREFACE

The seeds of this paper were first planted in early 1986 by Colonel Henry J. Waters, Medical Service Corps (MSC), and the late Lieutenant Colonel Harold G. Block, MSC, then commander and executive officer of the 1st Medical Group, Fort Hood, Texas. Both suggested that I do some work on the group's history; they said that it might be fun. In line with these suggestions, I hope eventually to expand my work to include a complete history of the 1st Medical Regiment-1st Medical Group from 1917 to 1945.

This current study was prepared while I was holding the fellowship in military medical history at the Uniformed Services University of the Health Sciences, Bethesda, Maryland, from August 1988 to August 1989. I am grateful to Dr. Robert J. T. Joy, M.D. (Col., Medical Corps, USA, ret.), chairman of the Section of Medical History at the university, for support, advice, and editorial review.

This paper relies rather heavily on primary source material, and several persons greatly assisted me in accessing archival sources. Of most help was Mr. Richard Boylan, chief of the Modern Military Records Branch of the National Archives, in the Washington National Records Center, Suitland, Maryland. His detailed knowledge of records relating to the Army Medical Department and its field units during the war uncovered several key documents for me that I might not otherwise have found. On several occasions, Albert E. Cowdrey, Ph.D., chief of the Special Histories Branch of the Center of Military History, U.S. Army, made documents filed in his office available to me. Richard J. Sommers, Ph.D., and his staff in the archives of the U.S. Army Military History Institute, Carlisle Barracks, Pennsylvania (housed, interestingly enough, in the former classroom building of the Medical Field Service School), were most helpful during my review of the William E. Shambora and Paul R. Hawley Papers in their holdings.

Several veterans of the 1st Medical Regiment and the 1st Medical Group were also of assistance. Al Gruenberg and Harold Schroeder provided me with membership rosters of the 1st Medical Regiment Association. Thomas S. Prideaux, Harry L. Gans (Col., MSC, USA, ret.), and Malcolm D. Blankenship all answered questions on their experiences in the 1st Medical

Group during the war. Louis H. Veigel and Judith (Veigel) Hall, brother and daughter of the late Colonel Lester P. Veigel, provided information on him otherwise no longer obtainable.

Dale C. Smith, Ph.D., and the late Dr. Peter D. Olch, M.D., of the Section of Medical History, Uniformed Services University of the Health Sciences; Major David W. Cannon, MSC, formerly of the Academy of Health Sciences, U.S. Army; and Captain Karin E. Neergaard, MSC, of the Walter Reed Army Institute of Research are all now more thoroughly knowledgeable of the history of the 1st Medical Regiment than they ever cared to be. Their interest in this project and their willingness to listen to my occasionally incoherent ramblings helped me to focus my thoughts on this project and eliminated the need for several preliminary drafts of this paper that might otherwise have been necessary.

Most of the sources referenced in this paper are primary sources—documents generated by the 1st Medical Group or some other agency during the war. Copies of a number of the sources are found in more than one location. For example, copies of the *Period Report of Medical Activities, 1st Semi-Annual—1945, 1st Medical Group* are located in the unit historical files of the 1st Medical Group, Fort Hood, Texas; the Special Histories Branch, U.S. Army Center of Military History, Washington, DC; and in Record Groups 112 and 407 of the National Archives. This is typical of many of the documents referenced in this study. In cases such as this, my policy was, first, to cite the most complete existing copy; second, if several copies were equally complete, to cite the original or most legible copy (since these documents were generated in the days before the advent of photocopy machines, some carbon copies were nearly illegible); and finally, if several copies were equally complete and legible, to cite the most readily accessible copy. Monthly after-action reports that I have cited were normally found as enclosures to annual historical reports; in these cases, the base document is not cited, only the after-action report. In all cases, enough information is provided to assist the interested reader in locating the report.

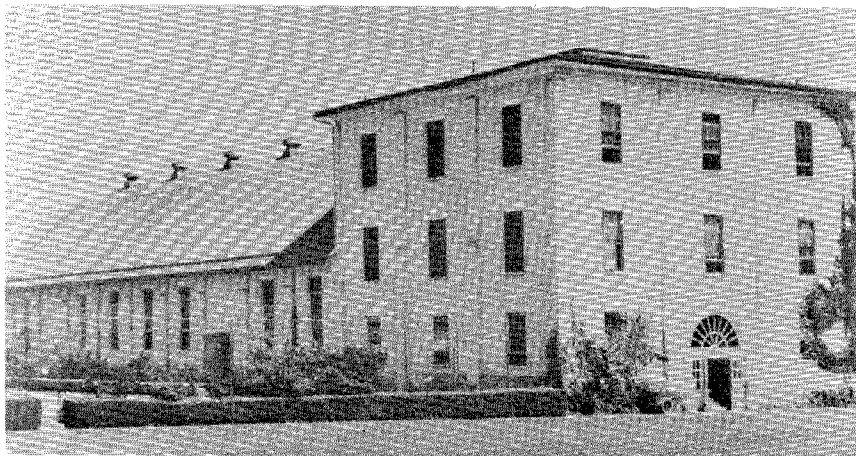
I. INTRODUCTION

The deliberate river-crossing operation is one of the most difficult tasks facing a ground combat commander. Forcing his way across a formidable natural barrier, expanding a bridgehead, and moving additional combat forces and their logistical support into the bridgehead for subsequent breakout—all compete for a commander's attention.¹ The medical planner also faces special problems in securing the movement of casualties from the bridgehead to treatment facilities. Yet little if any attention is devoted to these operations in Army Medical Department doctrinal literature or training courses. This leaves the modern health-services support planner only one place to turn for guidance—the past. In this paper, I shall examine the experiences of the U.S. 1st Medical Group and the support it provided to the XIII Corps in its crossing of the Roer River in late February 1945 and the XVI Corps in its crossing of the Rhine River in March 1945.

Background

The 1st Medical Group was originally organized in France in 1917 as the 1st Sanitary Train and provided division-level health-services support to the 1st Division. After participating in six campaigns with the division during the war² and in the occupation of Germany following the armistice, the unit returned to the United States on 25 August 1919. On 10 February 1921, the unit was reorganized and redesignated the 1st Medical Regiment. When the units of the 1st Division were scattered to posts along the eastern seaboard, the regiment was ordered to Carlisle Barracks, Pennsylvania, where it served as the demonstration unit for the newly established Medical Field Service School.³ The regiment would remain there until 15 June 1940, when it moved to Camp Ord, California.⁴ To serve with the regiment while it was at Carlisle Barracks was considered one of the most desirable assignments in the Medical Department, and many of the senior Medical Department officers during World War II had served in the 1st Medical Regiment, including virtually the entire medical chain of supervision of the 1st Medical Group in Europe.

The regiment had always trained hard. It had participated in the First Army maneuvers at Pine Camp, New York, in 1935; in the First Army maneuvers in August 1939; and in the Third Army maneuvers in Texas and Louisiana in April through June



The Medical Field Service School, Carlisle Barracks, 1940

1940. In the Texas-Louisiana maneuvers, the regiment completed the 2,900-mile round-trip from Carlisle Barracks to Texas and back a mere eleven days before departing on its permanent change of station move to Camp Ord, California.⁵

While the 1st Medical Regiment was continuing its training, the headquarters of the Army Ground Forces—responsible for organizing, equipping, and training units for their deployment overseas—was planning substantial changes in the organization of corps and field armies. The organization of these units would no longer be a fixed one, with a set number of divisions per corps, corps per field army, and a fixed support organization organic to the field army. Rather, organizations would become flexible, with units attached or detached as required to support tactical operations. All fixed nondivisional units—until then primarily regiments and separate battalions—were replaced with a building-block concept: separate battalions of the combat arms and separate companies of the combat support and combat service support branches would be task organized under separate group and battalion headquarters. Planners believed this would allow for the most efficient use of assets and provide greater flexibility to the ground combat commander.⁶

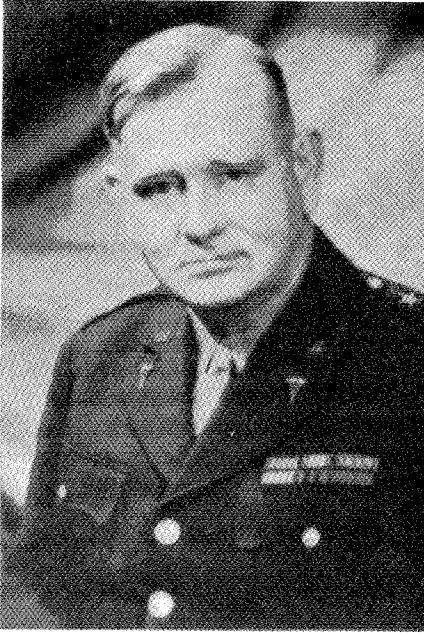
In accordance with this reorganization, the 1st Medical Regiment was broken up on 1 September 1943. The Headquarters and Service Company was reorganized and redesignated as the Headquarters and Headquarters Detachment, 1st Medical Group, and its subordinate companies were reorganized and redesignated as separate medical companies.⁷ Although the reorganiza-

Colonel William E. Shambora, U.S.
Ninth Army Surgeon



tion was not accepted wholeheartedly by the entire Army Medical Department, the 1st Medical Group, while in Europe, would serve under the Ninth Army Surgeon, Colonel William E. Shambora. Colonel Shambora had been the Army Ground Forces Surgeon at the time of the reorganization and supported the reorganization. He had, in fact, requested reassignment from the Army Ground Forces to a field army headquarters so that he could see for himself how well the system worked—and he was quite pleased with the results.⁸

Shambora had entered the Army Medical Department in 1925, shortly after receiving his M.D. degree from Georgetown University. After completing an internship at Fitzsimmons General Hospital, he held a variety of assignments, including tours as a company commander in the 1st and 12th Medical Regiments and as executive officer, S3, and adjutant of the 2d Medical Regiment at Fort Sam Houston, Texas. From 1937 to 1941, when he was reassigned to the Office of the Army Ground Forces Surgeon, he served as an instructor at the Medical Field Service School, first in the Department of Military Arts and later as both director of the Department of Logistics and as commander of the 32d Medical Battalion, the unit that had replaced the 1st Medical Regiment as the demonstration unit for the school. He completed the two-year course at the U.S. Army Command and General Staff School in 1935 and the Army War College in 1938.⁹ He was probably well known to



Maj. Gen. Paul R. Hawley, Surgeon
of the European Theater of Opera-
tions

the Surgeon of the European Theater of Operations, Major General Paul R. Hawley. Hawley's tour as a student at the Command and General Staff School had overlapped the second year of Shambora's, and Hawley had served as commander of the 1st Medical Regiment, director of the Department of Administration, and assistant commandant of the Medical Field Service School during Shambora's tenure as an instructor and department director at Carlisle.¹⁰

The group continued to train, supporting a number of large-scale exercises that required the headquarters to make a permanent change of station to Camp Carson, Colorado, and later to Fort Riley, Kansas. When the headquarters finally received orders to move overseas, the news was well received, according to one informal history of the group:

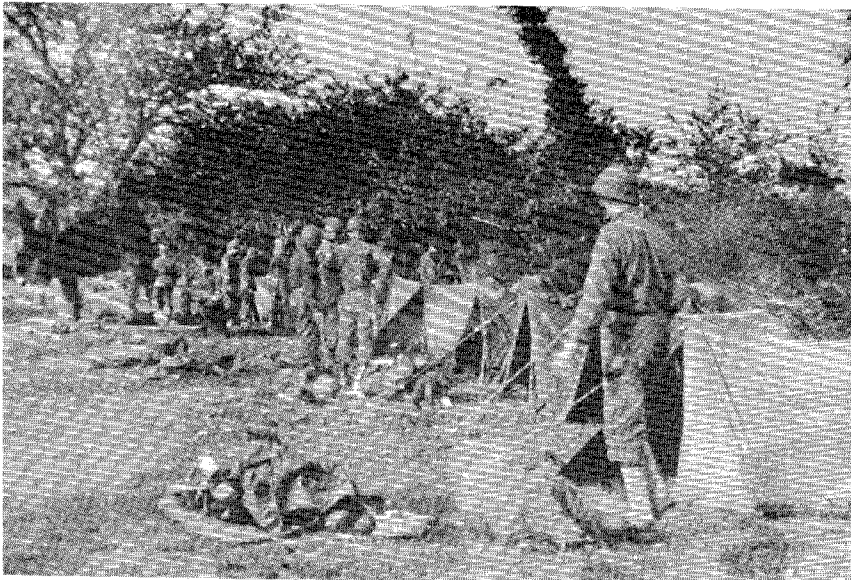
The morale was better than it had ever been, lifted above "excellent" by the realization that at last the unit was moving toward the service for which it had been training at Fort Ord, Camp White, Oregon, Camp Carson, Colorado, and Camp Funston [on the Fort Riley reservation], Kansas. "I'd begun to think the old 1st Medical Regiment's marching song, you know, the part that said 'we train, we train, and then we train some more,' was going to be our motto for life," one sergeant said, "Now, it's just to [sic] blamed good to be true that we're on our way."¹¹

The group moved to the Boston Port of Embarkation and on 7 October 1944 sailed for France aboard the transport *Mount Vernon*.¹² About two weeks prior to their departure, the group staff had been informed that they would be assigned to the U.S. Ninth Army, already in Europe.¹³ While the word of their assignment was spread among the officers, the men had no idea of their destination:

Rumors were in spite of all directives to the contrary, sending the unit to all parts of the globe. It was going "direct to India via the Mediterranean", "to Britain to re-stage", "to Britain for immediate shipment to France", "direct to France", "direct to Southern France for incorporation with a new army now forming". It was rumored that "trade goods" should fill all optional space in luggage since money meant nothing over there. Special emphasis was placed on liquor (worth a hundred dollars a bottle), "Soap" is a universal bartering item, and lipstick runs a close second to silk stockings, as an international currency.¹⁴

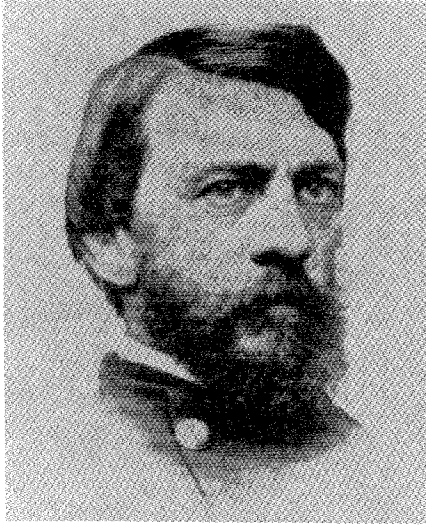
Since the 1st Medical Group had spent several years on the West Coast, and all of the other units that had been part of the 1st Medical Regiment had been deployed to the southwest Pacific, the rumors concerning its varied destinations were probably inevitable.

Arriving in England on 15 October 1944,¹⁵ the headquarters was loaded onto the South African liner *Llangibby Castle* and



Courtesy of Harry L. Gans (Col., USA, ret.)

The men of the 1st Medical Group set up pup tents on their initial entrance into France



Surgeon Jonathan Letterman, medical director of the Army of the Potomac during the Civil War

sailed for France on 17 October,¹⁶ landing on Omaha Beach on 18 October, where "Lt Col Veigel [the group commander], near the bow [of the landing craft transporting them to shore from the *Llangibby Castle*] for the privilege, was the first of the detachment to go ashore. He'd brought with him the descendants of the 1st Sanitary Train, that had evacuated the 1st Division in World War One."¹⁷ After a long period in the arrival staging area, uneventful save for the loss of the officers' footlockers, the 1st Medical Group moved into the Ninth Army zone. There, it was committed in support of the XIII Corps on 25 November 1944.¹⁸ The oldest color-bearing unit in the Army Medical Department was again, at last, at war.

Health Services Support Doctrine—1945

While the medical support system used by the United States Army in 1945 was, as it is today, basically a modification of the system originally developed by Surgeon Jonathan Letterman, medical director of the Army of the Potomac in 1863,¹⁹ there were a number of significant differences from the system used today. To place the 1st Medical Group's operations in the proper context, a review of the system in use in 1945 is presented here.

The health-services support system in 1945 was, as it is today, divided into five levels of care, called echelons. The first echelon of care, then as today, was unit-level health-services support. It began at the site of injury or illness and included self/buddy aid, treatment by the company aidman, and treatment

at the battalion or regimental aid station (see appendix for the chain of casualty evacuation).²⁰ In the infantry regiment, this echelon of care was provided by a regimental medical detachment of 10 officers and 126 enlisted men. The section was divided into a headquarters section, which operated the regimental aid station, and three battalion sections, each of which provided a battalion aid station, litter bearers, and company aidmen to one of the battalions organic to the regiment.²¹ The regimental aid station was organized in much the same manner as the battalion aid stations, with the addition of two Dental Corps officers. Because its capabilities and level of care were the same as that found in the battalion aid station, patients would not normally be evacuated from the battalion aid station to the regimental aid station. Rather, patients would be evacuated from the battalion aid station to the division collecting company, while the regimental aid station would provide care for personnel in the regimental rear area.²² In the other branches of the combat arms, these functions were performed by battalion medical detachments. Many of the units in the combat support branches also had organic medical detachments.²³ As World War II went on, it was found that the dental officers in the infantry regiments were underutilized and in many cases, they were removed from the regiments and used to form roving dental teams that provided dental care for a geographic area, rather than for specific units.²⁴

The second echelon of support, division-level health-services support, was provided in the infantry and armored division by the division's organic medical battalion. The battalion had two types of companies—collecting companies and clearing companies. Organic to the battalion were three collecting companies and a clearing company. The collecting companies had ambulance and litter-bearer sections and were responsible for evacuating casualties from the regiments to the division clearing station.²⁵ Normally, patients were evacuated by ambulance from the battalion aid stations, but if the terrain or the tactical situation would not permit this, they would be transported by the litter-bearer section from the battalion aid station to a collecting station established by the collecting company. There, they would be inspected by a Medical Corps officer, given emergency treatment if required, and then placed on ambulances for transport to the division clearing station.²⁶ At the clearing station established by the clearing company, patients were triaged (or sorted), and those who required care beyond the capabilities of the clearing station were prepared for transport to third-echelon

treatment facilities, with emergency resuscitative care provided as required. Patients who would be returned to duty in a short period of time—usually a few hours—would be held at the station until released.²⁷ This system is similar to the forward-support/main-support medical company concept we currently employ.

Second-echelon care for nondivisional troops assigned or attached to a corps was provided by a separate medical battalion assigned to the corps, which also provided first-echelon care to those units that lacked an organic medical detachment. In the army area, first- and second-echelon care was provided to units without an organic capability to provide such care by one of the medical groups assigned to the army.

The third echelon of medical support in World War II was the equivalent of what we today would call corps-level medical support but was provided during the war by the field army. This was because the corps, as employed in World War II, served only as a tactical headquarters, with little or no logistic or administrative capability. There was no overall medical command and control headquarters at this echelon. All third-echelon medical units were under the direct command of the army commander and under the technical supervision of the army surgeon.²⁸ In the Ninth Army, of which the 1st Medical Group was a component, Colonel Shambora was delegated to command all army medical units not placed under the control of a subordinate command of the army.²⁹ The third echelon of health-services support had three major missions. The first of these missions was to provide first- and second-echelon health-services support to those units in the army area that lacked organic medical assets. The second mission was evacuation of patients from second-echelon treatment facilities, and the third mission was hospitalization.

To provide for the first mission, the field army had assigned to it separate, numbered clearing and collecting companies. (See the glossary for the functions of various medical components of the Ninth Army.) The separate medical clearing company provided clearing support for up to 15,000 troops or support or reinforcement to divisional clearing elements. The basis of allocation for this unit was one company per supported division.³⁰ The mission of the separate medical collecting company was essentially the same as its divisional counterpart: to collect patients by litter or ambulance from first-echelon treatment facilities, provide them with needed stabilizing treatment at the

collecting station, and then transport them by ambulance to a supporting clearing company. In addition to collecting patients in the corps or army area, the company could also be used to support a divisional medical battalion with additional collecting assets. The normal basis of allocation was one company per supported division.³¹

To accomplish the second third-echelon mission—evacuation from second-echelon treatment facilities—the army used separate, numbered motor-ambulance companies. The motor-ambulance company's mission was to evacuate patients from second-echelon medical facilities belonging to divisional medical battalions or nondivisional clearing or collecting companies to third-echelon hospitals belonging to the field army. The basis of allocation of this unit was one company per 12,000 supported troops.³² These separate collecting, clearing, and motor-ambulance companies would be organized under separate medical battalions, which were in turn organized under a medical group headquarters, generally on the basis of one medical group per corps supported by the army.

The medical group and separate battalion headquarters were similar in organization and function. The group headquarters was composed of ten officers and twenty-four enlisted men. The commander (a colonel) and the executive officer (a lieutenant colonel) were both Medical Corps officers; the rest of the officers in the headquarters were Medical Administrative Corps officers. The headquarters provided command and control for six to eight subordinate battalions, companies, or separate units.³³

The separate medical battalion headquarters was composed of six officers, one warrant officer, and twenty-two enlisted men. With the exception of the commander and executive officer (who were Medical Corps officers) and the personnel-services warrant officer, all officers of the headquarters were Medical Administrative Corps officers. The battalion provided command and control for three to six subordinate medical companies and provided maintenance and personnel-services support to its subordinate units through sections formed by attaching mechanics and clerks to the battalion from companies under its control.³⁴

The final service provided by third-echelon health-services support was hospitalization. To provide this service, the field army used three types of hospitals: the 750-bed evacuation hospital, the 400-bed evacuation hospital (semimobile), and the field hospital. The evacuation hospital had almost no mobility through its organic transportation assets, nor was its staff



An evacuation hospital in France (World War II)

trained in unit movements. It was essentially a fixed medical installation designed to be moved infrequently.³⁵

The evacuation hospital (semimobile) was a 400-bed facility with the same mission as the 750-bed evacuation hospital.³⁶ One important difference between the two was that the semimobile evacuation hospital was equipped with more trucks than the evacuation hospital, making it about 25 percent mobile in organic transportation assets. Additionally, the staff was trained in moving the facility and could move in eight to ten hours (after all patients had been removed) and could reestablish the facility in four to six hours after arriving at a new location.³⁷

The field hospital was especially valuable, as it could be established as a single 400-bed facility or as three 100-bed facilities, which gave the army surgeon a great deal of flexibility in providing needed health-services support.³⁸ The field hospital was considered a semimobile station hospital designed to provide "definitive surgical and medical treatment to troops in the theater of operations where fixed facilities [did] not exist, and where construction of fixed facilities [was] undesirable."³⁹

In practice, the hospital units of the field hospital were often employed in close proximity to a division clearing station, where they could provide more definitive care than that available in

the division—much the same way in which mobile army surgical hospitals would be employed in Korea a few years later. The lack of sufficient surgeons and nurses in the hospital units of the field hospital was, in fact, one of several factors leading to the development of the mobile army surgical hospital after the war.⁴⁰

A hodgepodge of additional units, serving directly under the army surgeon, provided medical logistics, laboratory, veterinary, and other ancillary services to the army.⁴¹ The most important of these units was probably the medical depot company. Commanded by a lieutenant colonel, the company—with 13 officers, 1 warrant officer, and 136 enlisted men organized into a headquarters, a maintenance platoon, and 3 storage platoons—was the equivalent of the modern medical-supply, optical, and maintenance (MEDSOM) battalion. The three storage and issue platoons gave the company the ability to provide continuous support while displacing over large lateral distances. The company's mission was to provide third- and fourth-level medical maintenance of medical equipment; to replace and repair spectacles and dental prosthetic appliances; and to receive, store, and issue medical supplies in support of 125,000 combat-zone troops.⁴²

Also found in the field army, and helping to partially counteract the lack of physicians in the field hospital, was an assortment of surgical augmentation teams. There were seven types of surgical teams in World War II, all organized under the blanket Table of Organization and Equipment 8-55, *Professional Services*. These included team EA, general surgery; team EB, orthopedic surgery; team ED, maxillofacial surgery; team



A field hospital in the Mediterranean theater (World War II)



In World War II, general hospitals were sometimes set up in tents
(example from Constantine, Algeria)

EE, neurosurgery; and team EF, thoracic surgery—each of the above with three officers, one nurse, and three enlisted men. There were also team EC, shock treatment, with one officer, one nurse, and three enlisted men, and team EG, gas treatment, with one officer and three enlisted men. The EA through EF teams provided, in effect, additional staffed operating tables for the facilities to which they were attached, while team EG provided oxygen therapy for lung-irritant casualties. The teams were organized under a headquarters to form an auxiliary surgical group; the Fifth Auxiliary Surgical Group supported the Ninth Army.

The fourth echelon of care corresponded to what we today would call communications zone—or echelons above corps—medical support. It was provided in 1,000-bed or larger general hospitals, usually grouped together in hospital centers, station hospitals, and convalescent centers. With an evacuation policy sometimes as long as 120 days, this echelon of care was designed to return the maximum number of patients to duty within the theater.⁴³

The fifth echelon of care formed the hospital base in the United States. A patient returned from an overseas theater would receive care in one of sixty-six named general hospitals,⁴⁴ numerous station hospitals, convalescent centers, or in Veterans Administration facilities. As a general rule, a patient would not be evacuated to the United States unless his injuries required an extremely long convalescent period, the equipment or facili-

ties were not available to treat his injuries in theater, or his injuries would result in his being medically discharged upon recovery.⁴⁵

Governing all medical planning were a series of general doctrinal rules, most of which are as valid today as they were in 1945:

1. Commanders of all echelons are responsible for the provision of adequate and proper medical care for all noneffectives [persons whose medical condition prevents them from performing their military duties] of their command.
2. Medical service is continuous.
3. Sick or injured individuals go no farther to the rear than their condition or the medical situation warrants.
4. Sorting of the fit from the unfit takes place at each medical installation in the chain of evacuation.
5. Casualties in the combat zone are collected at medical installations along the general axis of advance of the units to which they pertain.
6. Medical units must possess and retain tactical mobility to permit them to move to positions on the battlefield and enable them to move in support of combat elements.



An example of a general hospital in a fully established site (at Pistoia, Italy)

7. Mobility of medical installations in the combat zone is dependent upon prompt and continuous evacuation by higher medical echelons.
8. The size of medical installations increases and the necessity and ability to move decreases the farther from the front lines these units are located.
9. Medical units must be disposed so as to render the greatest service to the greatest number.⁴⁶

These doctrinal statements should be kept in mind by the reader during the discussion of medical support that follows.

Command and Control

One problem with the medical organization used in World War II was the lack of an overall medical command and control headquarters at the third and fourth echelons of health-services support—a problem not completely and adequately addressed by the Medical Department until well into the 1960s.⁴⁷ In support of a typical corps was a separate medical battalion—under the command of the corps commander and the technical supervision of the corps surgeon—which provided second-echelon care to non-divisional units assigned or attached to the corps. Patients were evacuated from the corps' divisions and from its attached medical battalion by a medical group of the field army—in this case, under the command of the army commander and the technical supervision of the army surgeon. The medical group also provided second-echelon health-services support to the units of the army operating in the corps area but not attached to the corps. The group evacuated patients to the evacuation hospitals of the field army, again under the command of the army commander and the technical supervision of his surgeon. This meant that health-services support for the corps was provided, for the most part, by units not under the control of the corps. In turn, the medical groups evacuated casualties to hospitals not under their control—hospitals that sometimes received patients from more than one corps. A lack of close coordination at any point could have created disastrous results for the wounded.

To prevent such problems in the Ninth Army, Colonel Shambora held weekly meetings at the army headquarters with his corps surgeons, hospital commanders, and medical group commanders, where he discussed problem areas and support of future operations (with occasional additional meetings as required by the circumstances).⁴⁸ The XIII Corps Surgeon, Colonel Dean Schamber, held similar weekly meetings at his

office with his division surgeons, his medical battalion commander, and the "supporting medical group commander"⁴⁹—as did the XVI Corps Surgeon, Colonel Thomas Furlong.⁵⁰ A review of unit and staff section journals for these headquarters shows a constant flow of visitors (commanders, staff officers, and liaison officers) among the headquarters involved. While problems would still occur, most notably during the Roer River crossings, this coordination no doubt prevented many problems before they could affect patient care.
